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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility from 1/25/10 through 1/29/10, in accordance with 42 CFR Chapter IV Part 483 Requirements for long Term Care Facilities. The census was 179 residents. The sample size was 27 residents, which included 3 closed records and 5 unsampled residents. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 3 of 27 residents or their legal representatives were informed of the risks and	F 154		3/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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benefits of a psychotropic medication (Residents #2, #6, #17).

Findings include:

Resident #2

Resident #2 was originally admitted to the facility on 7/29/09, with re-admission on 9/4/09. Diagnoses included prostate cancer, diabetes, and debility.

Record review revealed that the resident was alert and oriented, with independent decision-making ability. Medication orders included the antidepressant Effexor 75 mg (milligrams) daily "for depression," prescribed on 1/5/10. The resident's record included a consent for Effexor, but it was unsigned.

The nurse on duty, Employee #13, confirmed on 1/26/10 at 1:30 PM that Resident #2 had been receiving Effexor since 1/6/10, and that the resident had not signed the consent, or been told about the risks and benefits of the medication. The DON agreed that informed consent for Effexor should have been obtained by the resident prior to administration.

Resident #6

Resident #6 was admitted to the facility on 1/4/07, with a re-admission on 5/19/08. Her diagnoses included hemiplegia from a previous cerebral vascular accident, Type II diabetes and hypertension.

On 10/7/09, an order was written for Resident #6 to receive Ativan 0.5 mg orally twice a day and 1

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F 154	Continued From page 2 mg at bedtime. The medication was to be given for anxiety. Review of the Medication Administration Record (MAR) for October revealed that the medication was started on 10/07/09. The Psychotropic Medication Informed Consent for the medication was not signed by the resident's legal representative until 10/28/09. There was no evidence that a verbal consent had been obtained prior to the written consent. An additional order, for Depakote Sprinkles 250 mgs three times a day, was also written on 10/07/09. This medication was to be given as a mood stabilizer. The Depakote Sprinkles were also started on 10/07/09. The consent for the medication was not signed by Resident #6's legal representative until 10/28/09. There was no evidence of a verbal consent consent being obtained prior to the administration of the first dose. Resident #17 Resident #17 was admitted to the facility on 1/24/08. There was a re-admission on 3/13/09. Diagnoses included general muscle weakness, debility, convulsions and rheumatid arthritis. On 11/12/09, an order was written for Valium 5 mg to be given every eight hours for panic attacks as evidenced by trembling, racing thoughts and "panicky." The record contained a Psychotropic Medication Informed Consent which had been filled out and witnessed by facility staff; however Resident #17 had never signed the consent.	F 154		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and	F 164		3/10/10

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F 164	Continued From page 3 confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident information was consistently maintained in a confidential manner. Findings include: During a tour of the 400 Hall of the Denton building on 1/25/10 at 8:45 AM, it was observed that a medication administration record (MAR)	F 164		

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F 164	Continued From page 4 book on a medication cart was left open for three minutes without a staff member nearby, exposing a resident's medical information. During the initial tour of the 200 Hall at approximately 9:00 AM on 1/25/10, it was observed that one of the two medication carts had its MAR book open in such a way that a resident's name, diagnoses, medications and their purposes were visible for anyone passing to see. The medication nurse was not present at the medication cart with the exposed MAR. Approximately five minutes later, when passing the cart a second time, the MAR was open the same way to another resident's medical information. An interview with the licensed practical nurse (LPN), Employee #5, at the time confirmed she offset the MAR pages so that she could use a cover sheet to cover resident information. Employee #5 did not realize the way she offset the pages resulted in revealing the very information she was trying to cover.	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to obtain the proper consent before implementing a physical restraint for 1 of 32 residents (Resident #7).	F 221		3/10/10

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F 221	Continued From page 5 Findings include: Resident #7 Resident #7 was admitted to the facility on 8/14/07, with a re-admission on 7/3/09. Diagnoses included dysphasia, Type II Diabetes, dementia, anxiety and hypertension. Review of the record disclosed a form entitled, "Physical Restraint Informed Consent." The consent described the type of restraining devise as a reclining wheelchair, to prevent the resident from leaning forward and sliding out of the chair. The medical reason for the restraining device was described to be dementia and debility. The consent was signed and dated by a facility representative, but the form was not signed by Resident #7 or his authorized representative. Resident #7 was observed to be in reclining wheelchair.	F 221		
F 241 SS=C	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff consistently knocked on doors before entering resident rooms and served meals in a way to promote resident dignity.	F 241		3/10/10

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F 241	Continued From page 6 Findings include: During a tour of the facility on 1/25/10 at 8:45 AM, it was observed on two occasions that nursing staff did not knock on the door of resident rooms before entering. During the medication pass on 1/26/10, at approximately 8:30 AM, it was observed that Employee #12 entered Room 121 four times, each time without knocking before entering. During two noon dining observations on the main dining room on 1/25/10 and 1/26/10, it was observed that residents sharing a table did not receive their meals at the same time. It was observed that the kitchen staff served the food from a steam table, where the food was plated. Usually four plates were placed on a serving tray and this tray was taken to the center of the dining room where facility staff would then serve the plates to the specific residents. On 1/25/10, it was observed that for two tables, three of four residents were served their plates. The fourth residents received their plate approximately five minutes after their table mates had been served. On 1/26/10, one resident was observed to wait approximately seven minutes after his table mates were served. This resident watched each plate that passed his table. It was observed during both of these dining observations, that residents were given beverages, and soup or salad, and then waited 30 minutes before being served the hot entree. It was observed during these dining observations that between one to three residents appeared to be asleep, head on chest, not engaging in table	F 241		

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F 241	Continued From page 7 conversation for a minimum of 15-30 minutes between the serving of beverages and the main course. It was also observed that three residents left the dining room before the main entree was served. An unsampled resident was not served lunch by 12:30 on 1/26/10, and had to ask for a sandwich to take with him to his doctor's appointment. An interview with the Dietary manager (Employee #11) on 1/27/10, revealed there had been no arrangements for this unsampled resident to receive an early meal.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, and record review, the facility failed to provide needed transportation for 1 of 5 unsampled residents (Resident #29). Findings include: A random observation on 1/28/10, revealed an unsampled resident (#29) had missed his dental appointment because the facility transport van was being used to take residents to an activity	F 246		3/10/10

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F 246	Continued From page 8 outing. Review of the transport log revealed Resident #29 had been scheduled to be taken to his 10:00 AM dental appointment at 9:15 AM. The activity outing was scheduled for 10:00 AM. Resident #29 did acknowledge he knew that out of facility activities were scheduled every Thursday, but had forgotten about this when he made the appointment. An interview with the van driver (Employee #14) at 10:10 AM on 1/28/10, revealed he had just returned from taking the residents to their out of facility activity and arrived too late for the unsampled resident to be taken to his dental appointment. He did acknowledge that he had attempted to take Resident #29 to his appointment earlier, but that Resident #29 could not be ready earlier than what had already been scheduled. Employee #14 acknowledged he thought he could be back in time. Employee #14 also acknowledged that both facility vehicles needed to be used for the residents going on the activity outing. An interview with the transport scheduler (Employee #13) on 1/28/10, confirmed that residents with appointments should have preference over residents going on activity outings. Employee # 13 could not offer any explanation why this didn't happen today.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being	F 248		3/10/10

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of each resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to ensure that 2 of 27 residents who spent most of the day in their rooms were provided with activities which focused on their interests and followed their care plans (Residents #2, #11).

Findings include:

Resident #2

Resident #2 was originally admitted to the facility on 7/29/09, with re-admission on 9/4/09. Diagnoses included prostate cancer, diabetes, and debility.

The following "weekly summary" note, dated 12/31/09, was recorded in the Nurse's Notes section of the resident's record: "A & O (alert and oriented), needs anticipated, stays in bed all the time, refused to get up or prefers to stay in bed with Foley catheter intact..."

A review of the resident's Activities Evaluation, completed on 7/29/09, indicated that the resident preferred activities in his own room, and that animals, current events, movies, and music were very important to him.

The resident's activities care plan revealed the following goal: "Resident will receive 1:1 (one-to-one) visits in room 1-2x/week." The care plan did not indicate the interests of the resident, or what activities assistants should focus on

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during the 1:1 visits. The most recent Activity Progress note for Resident #2 was dated 11/5/09, and it read, "Care plan has been modified to include 1:1 visits from staff in room. Staff will monitor independent interests to determine level of engagement."

A review of the resident's "Daily Participation Record," used to record activity involvement, indicated that the only activities the resident was involved in for the month of November was watching TV, and that during the month of December, the resident watched TV daily and had three pet visits.

In an interview with the Activities Director on 1/26/10, the Director acknowledged that Resident #2 did not receive room visits one to two times per week as care planned, because of staff changes. The Director agreed that the care plan should have included specific interests of the resident.

Resident #11

Resident #11 was admitted to the facility on 11/28/09, with diagnoses of endometrial cancer, abdominal surgical wound dehiscence, cellulitis, decubitus ulcer of the buttocks, diabetes type II, difficulty walking, anemia and muscle weakness.

On 1/25/10, Resident #11's medical records were reviewed. Physician's progress notes, nurse's notes and physician's orders indicated since admission the resident had declined, with the resident being placed on comfort care as of 12/27/09.

On both the mornings of 1/25/10 and 1/26/10,

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Resident #11 was observed resting quietly in her bed. The blinds to the outside window were closed, there was no radio or books in the room, the television was off and the privacy curtain was closed so that the resident could not be observed or see out. There were only two personal items, which consisted of framed pictures of a pet and a family member on an overbed table. The resident was dressed in a hospital gown, she had no roommate and was on isolation precautions.

Review of Resident #11's activities evaluation, which had been completed on 12/3/09, indicated that the resident preferred activities in her own room. The activities evaluation indicated the resident was interested in movies, music, reading and television, and that these items were very important to the resident. A comment on the evaluation stated, "...will isolate herself need encouragement..." Review of the activities progress notes revealed two entries dated 12/3/09 and 12/8/09. Both entries indicated the resident would be provided with appropriate activities. The last entry indicated the resident was a hard one to get to activities and that the resident had indicated she was too tired to attend. There were no further progress notes or evidence in the records that room activities had been engaged in or that books, movies, music or other specified interests had been provided or that one to one activities had been developed for the resident.

On 1/26/10, the status of Resident #11's condition, activities participation and plan of care were discussed with the facility's Director of Nursing, Employee #9 and on the morning of 1/27/10 with the facility's Activities Director, Employee #7.

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F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and resident interview, the facility failed to provide services necessary to meet the psychosocial well being for 4 of 27 residents. (Resident #4, #17, #9, #21) Findings include: Resident #4 Resident #4 was admitted to the facility on 6/4/07. Diagnoses included dementia, convulsions and debility. On 3/3/09, Resident #4 was seen by a psychiatrist who recommended a guardianship of person and state. There was no evidence in the record that this recommendation had been pursued. The record indicated that the resident with a diagnosis of dementia and cerebral degeneration was continuing to sign consents for psychotropics and immunizations and was being consulted for decisions regarding his care. An interview was conducted with the social worker, Employee #2, on 1/27/10. The social worker disclosed that she was not aware of the recommendation.	F 250		3/10/10

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F 250	Continued From page 13 Resident #17 Resident #17 was admitted to the facility on 1/24/08, with a readmission on 3/13/09. Diagnoses included general muscle weakness, debility, convulsions and rheumatoid arthritis. The resident had been denied the use of her power scooter and was unsure of the reason. Review of the social services notes dated 8/21/09, disclosed that Resident #17 had discussed the desire to use her power scooter with the social worker. The resident was told that she needed to be evaluated by therapy for safety prior to being able to use the scooter. There was no evidence that the social worker made any attempt to determine the status of the safety evaluation or than any other attempts were undertaken to ease the resident's concerns over the use of her power scooter. Resident #9 The social worker (Employee #2) was interviewed on 1/28/10, regarding her contact with residents to ensure the residents (and possibly their families) were receiving the services they needed when decisions for Hospice or other end of life decisions were made. Employee #2 acknowledged she did not provide any interaction to residents/families who were considering Hospice. Employee #2 also confirmed she did not follow up on clarifying responsible parties, family point of contact or discussing alteratives when a resident was not able to give consent for development of power of attorney. The following was one specific instance.	F 250		

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Resident #9 was admitted to the facility on 11/10/08, with the primary diagnoses of peripheral vascular disease and dementia. At the time of her admission, it was indicated that she was her own responsible party. The resident did not have any advance directives on file.

Review of the clinical record revealed the face sheet that contained the contact information specified that a daughter-in-law was the primary contact. The release of information form signed by the daughter-in-law implied there was a power of attorney. This form also revealed a friend, the daughter-in-law and a grandson were to be the only individuals to have access to Resident #9's medical information although the Resident #9 had three sons. The record also revealed that the daughter-in-law signed consents for physical restraints.
An undated entry on Resident #9's face sheet indicated the son was to be called before the daughter-in-law, but no other documentation was ever changed to allow the son permission to this access.

Review of the clinical record also revealed consents signed by an individual identified as Resident #9's legal representative. These included consents for treatment as well as psychotropic drug management. Review of the clinical record revealed this individual could have been either a son or grandson, who shared the same name, but there was no clarification as to why Resident #9 was not signing these forms herself. There was also no indication the resident had been informed of these changes to her plan of care.

An interview with the social worker, Employee #2,

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on 1/28/10, revealed she had "always" spoke to the individual she thought was the son. She could not clarify whether there were two individuals with the same name or whether the "son" and the "grandson" were the same person. The social worker acknowledged Resident #9 was too demented to make choices for herself, but acknowledged that there were not attempts to inform Resident #9 of care need changes. The social worker confirmed there was no plan of care specifically identifying Resident #9's inability to make her own decisions, but lacked a power of attorney, therefore requiring a family member to make decisions.

On 1/28/10, the social worker reported she had contacted the son and found out that both he and his son shared the same name, but that he (the son) was to be the primary contact. The son also confirmed the "daughter-in-law" had been his wife, but they were divorced and she had since remarried. The son had no knowledge of who the friend was that was listed as having permission for medical information, but thought it might have been his ex-wife's current husband. The social worker acknowledged she was unaware of these family dynamics.

Resident #21

On 1/28/10 at 12 PM, Resident #21 was observed in the dining room being assisted with a pureed diet by a staff member. On 1/28/10 at 1:45 PM an interview was held with Resident #21's family member. The family member was asked if Resident #21 had dentures at the facility. The family member stated the resident did have dentures, but they had been lost about 6 to 8 months ago. The family member indicated the

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facility was aware the dentures were missing.

A joint interview was held with Employees #2 and #9 on 1/29/10, at 9:30 AM. Employee #2 communicated that the process for handling lost items was that when a staff member became aware of a resident's lost item, the staff member started a search. If the item was not found, the staff member was to initiate a form titled, "Compliment and/or Concern Form." Employee #2 explained that the forms were located on each nursing station. The form was then given to the Social Service Department track for follow-up. Employee #2 shared that she kept a log of all lost items reported to the Social Service Department, and that "...there should be some documentation in the nursing notes and social services notes," regarding the missing dentures and the steps taken to find them.

On 1/29/10 at 9:50 AM, Employee #2 reviewed the Social Services Department's grievance tracking log for the past year. There was no entry on the log regarding Resident #21's missing dentures. The employee stated, "I don't have any record that a form was submitted. I can only record what I am made aware of."

An interview was held with Employee #6, identified as the nurse unit manager for Station 1. Employee #6 was asked what process she followed when notified of a resident's missing item. The nurse reported that a search for the item would be conducted immediately, and "I would notify her (Employee #2)." Employee #6 further explained she would notify the social worker, Employee #2, verbally. When asked about the "Compliment and/or Concern Form," the nurse indicated Employee #2 would fill out the

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F 250	Continued From page 17 form, and that the forms were not kept at the nursing station. A review of Resident #21's record revealed there was no documentation in the social service notes from 3/19/09 through 1/28/10 regarding the resident's lost dentures. A licensed nurse documented on a nurses note, dated 5/27/09 at 2:00 PM, "Res (resident) c/o (complains of) not being able to chew her food due to lost dentures." There was no documentation the licensed nurse initiated a search for the dentures or initiated the concern form. There was no further documentation in the nursing notes regarding Resident #21's lack of dentures. On 1/29/10, at 10:15 AM, Employee #2 was shown the 5/27/09 nursing entry. Employee #2 stated, "That nurse should have completed the form." The facility's policy titled, "Grievance Procedures," with a revision date of 6/17/08, read, "The Social Services Director is responsible for the following...Coordinating orientation and in-services training to ensure that all facility associates know about the facility grievance procedures and their role in providing responsive customer services to residents and families in grievance resolution..."	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		3/10/10

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objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on resident interview and record review, the facility failed to develop a comprehensive care plan for communication for 2 of 27 residents (Resident #7 and Resident #17).

Findings include:

Resident #7

Resident #7 was admitted to the facility on 8/14/07, with a re-admission on 7/3/09. Diagnoses included dysphagia, Type II diabetes, dementia and hypertension.

In an attempt to talk with the resident on 1/25/10, it was noted that his speech was severely impaired and difficult to understand. Review of the Minimum Data Set (MDS) dated 10/27/09, and identified as a quarterly assessment, disclosed that it was documented in section C4 that Resident #7 could make himself understood.

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F 279	Continued From page 19 Communication was not identified in the Resident Assessment Protocol Summary as a problem, nor was a care plan developed for communications. Resident #17 Resident #17 was admitted to the facility on 1/24/08, with a re-admission on 3/13/09. Diagnoses included general muscle weakness, debility, convulsions, and rheumatoid arthritis. On 4/6/09, a physician's order was written for Resident #17 to have 240 cc water or juice by mouth every three hours while awake. Review of the record revealed a care plan for potential fluid volume deficit due to diuretic use; however the incorporation of the order for 240 cc of water or juice every three hours while awake was not included in the care plan approaches.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		3/10/10

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F 280	Continued From page 20 each assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to develop a comprehensive care plan for hospice for 1 of 27 residents (Resident #19). Findings include: Resident #19 had been a resident at the facility since 2/20/08, with primary diagnoses of chronic obstructive lung disease, dementia and hypertension. The clinical record revealed a decline in Resident #19's condition. On 10/22/09, Resident #19 was admitted to hospice care with a diagnosis of failure to thrive. Review of Resident #19's clinical record revealed no specific hospice care plan, although the care plan was updated 11/5/09. Interviews with staff acknowledge that the hospice agencies would review the current care plans and sign the back of the care plans to reflect that they agree with the facility plan. Review of the care plans for Resident #19, revealed no hospice signatures on the back of the care plans, except for comfort care.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		3/10/10

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F 281	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and interviews, the facility failed to ensure that services provided met professional standards of quality, specifically for following physician orders, medication administration, recaps, and special diet needs for 4 of 27 residents (Residents #10, #9, #1, #3). Findings include: The "Nevada Nurse Practice Act" defined that both the licensed practical nurse (LPN) and the registered nurse (RN) responsibilities in implementing strategy of care were to administer prescribed medications. RNs and LPNs were also responsible for verifying orders for accuracy. Resident #10 Resident #10 was admitted to the facility on 12/8/09, following an acute care hospitalization for intracranial hemorrhage. His primary diagnoses also included insulin dependent diabetes. His admission orders to the facility included fingerstick blood sugars (FSBS) to be checked every morning. The physician's orders included a Novolog Insulin sliding scale coverage for these fingersticks: 2 units (u) subcutaneous (sq) for FSBS 150-200 4 u sq for FSBS 201-250 6 u sq for FSBS 251-300 8 u sq for FSBS 301-350 10 u sq for FSBS 351-400 12 u sq for FSBS greater than 400, and to notify MD. Review of the medication administration records	F 281		

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(MAR) for 12/2009 and 1/2010, revealed that Resident #10 did not receive the prescribed sliding scale insulin doses for the following elevated FSBS:
1/6/10 FSBS was 156 (2 u were to be given)
1/7/10 FSBS was 206 (4 u were to be given)
1/8/10 FSBS was 234 (4 u were to be given)
1/14/10 FSBS was 176 (2 u were to be given)
1/15/10 FSBS was 160 (2 u were to be given)
1/21/10 FSBS was 153 (2 u were to be given)

There was no evidence the physician was informed of the blood sugars, that the sliding scale insulin had not been given, nor any change to the FSBS sliding scale coverage.

An interview with the Resident Care Manager (Employee #3) for Resident #10, confirmed the sliding scale insulin coverage should have been followed.

Resident #10's October's MAR indicated that flu vaccine had been given, but there was no route or dose listed to demonstrate the ordered dose and route were followed.

Resident #20 was re-admitted to the facility on 8/7/09. Her admitting orders indicated that the standing orders for fingerstick blood sugars was not to be included as part of her orders. Review of the monthly recaps revealed that these standing orders were included as part of her care. An interim order could not be found.

Resident #9

Review of Resident #9's medical orders revealed that the Hospice order that was initiated 12/24/09, was not transcribed onto the recap for January,

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2010.

An interview with the Director of Nursing (Employee #9) at 12:30 PM on 1/28/10, confirmed the RN or LPN reviewed the recaps for accuracy.

Resident #1

Resident #1 was originally admitted to the facility on 12/15/09, with readmission on 1/13/10. Diagnoses included esophageal cancer, dysphagia, chronic obstructive pulmonary disease, gastrostomy tube, and weight loss.

Medication orders included Lisinopril 10 milligrams (mg) twice daily and Megace 400 mg twice daily, as well as a "cocktail," ordered for nausea on 1/22/10, for three days before meals, consisting of Donnatal 5 milliliters (mL), viscous Xylocaine 0.5 mL, and Maalox 20 mL. Review of the resident's Medication Administration Record (MAR) on 1/25/10 at 2:00 PM, revealed that the the Lisinopril and Megace were scheduled to be given in the morning, but there were no signatures indicating whether or not they were given. For the 3-day period that the cocktail was supposed to have been given, the MAR was blank, except for a signature indicating that the resident had refused that medication at 4:30 PM on 1/24/10.

In an interview with the med pass nurse, Employee #1, on 1/25/10 at 2:10 PM, the nurse communicated that the resident had refused his morning medications, but she had not recorded that fact on the MAR or on the Nurse's Medication Notes. The nurse acknowledged, "I fill it in before I leave. I know the charting is bad." Employee #1 also explained that the resident had refused the

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cocktail since it had been ordered on 1/22/10, but the nursing staff had not documented the refusals on the MAR.

Resident #3

Resident #3 was originally admitted to the facility on 1/7/02, with readmission on 9/3/09. Diagnoses included dysphagia, gastroesophageal reflux disease, debility, and hypertension. The diet order for the resident was "mechanical soft with nectar thick liquids."

On 1/28/10 at 8:30 AM, the nurse at the 100 Hall, Employee #18, was interviewed if she used thickened liquids for Resident #3 during med pass. The nurse responded, "No," and then, after looking at the MAR, continued, "It's in the MAR, but I didn't see it." When asked how she would measure the thickening agent, the nurse said, "I would just have to estimate."

One 1/28/10 at 10:00 AM, the speech therapist, Employee #19, was interviewed. When asked about Resident #3's swallowing ability, the therapist responded, "She has to be on thickened liquids, otherwise she coughs." According to a progress note written by Employee #19 on 11/6/09, "This intervention (using nectar thick liquids) is medically necessary due to swallowing deficits with oropharyngeal dysphagia impact safety of swallowing and placing patient at high risk of aspiration/penetration and silent gross aspiration on thin liquids."

Review of Resident #3's record revealed that the speech therapist was concerned that the consistency of the milk given to Resident #3 was accurate. On the "Rehabilitation Services

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F 281	Continued From page 25 Multidisciplinary Screening Tool," dated 12/16/09, Employee #19 wrote, "Spoke with staff and informed nurse/CNA's to make sure milk NTL (Nectar Thickened Liquid) as coming out thinner than nectar thick and makes patient cough and risk of aspiration/penetration high. Staff verbalized understanding and stated they would thicken to nectar thick if liquid does not come out to correct consistency..called dietary manager and discussed milk not right consistency." On 1/28/10 at 12:00 PM, the dietary aide responsible for preparing thickened liquids, Employee #20, was interviewed. The employee explained that she could determine how much thickening agent to use by observing the results: "With pudding (consistency) it gets thick; nectar (consistency) is pretty close to pudding- not quite; honey (consistency) is just enough to give a hold." The Dietary Manager confirmed that kitchen staff did not measure the thickener using the guidelines on the thickening chart.	F 281		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of three medication passes completed on two halls in which a total of 48 opportunities were viewed, it was determined that there were five medication errors, resulting in a 10% error rate. Findings include:	F 332		3/10/10

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During observation of a medication pass on 100 Hall at approximately 8:30 AM on 1/26/10, it was noted that Resident #33 received an enteric coated aspirin, 81 mg. Review of the physician's order disclosed that the resident was to have received regular aspirin.

Resident #33 also received Calcium 600 mg with Vitamin D orally. Review of the physician's orders disclosed that the Calcium was to be given in a chewable form.

During an observation of the medication pass on 1/27/10 on Station 3, the following was noted:

At 8:05 AM, Employee #15 prepared the medications for Resident #30. One of the medications included an eye drop. The eye drop medication bottle label indicated the medication was Timolol and one drop was to be placed in the left eye at bedtime. Employee #15 took the eye drop bottle into Resident #30's room. Before the employee could administer the eye drops, Employee #15 was asked to read the entire label on the eye drop bottle. The employee noted the medication was to be given at bedtime. Employee #15 returned to the medication cart and retrieved another eye drop bottle. The label indicated the medication was Alphagan 0.15%, and one drop to both eyes to be administered three times a day.

A review of the physician orders for Resident #30 verified the Timolol was to be given at bedtime and the Alphagan was to be given three times a day.

At 9:10 AM, Employee #1 prepared the

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F 332	Continued From page 27 medications for Resident #31. Employee #1 administered two Simethicone 80 mg tablets (for a total of 160 mg) to Resident #31. A review of the physician orders for Resident #31 revealed the physician had written the order for "Simethicone 125 mg." An interview was held with Employee #1 regarding the discrepancy in the amount of Simethicone administered. Employee #1 indicated the medication was a "stock" medication and only came in doses of 80 mg. The employee had not notified the physician of the inability to administer 125 mg of Simethicone. During the review of the physician orders for Resident #31, an order was noted for Potassium Chloride 20 meq by mouth every day. Employee #1 was not observed to pour or administer Potassium Chloride. An interview was held with Employee #1. When told of the finding, Employee #1 pulled the medication packet for the Potassium Chloride. The medication was a large white pill. Employee #1 stated, "I know I didn't give that medication because the resident would have asked for it to be crushed. I must have missed it."	F 332		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by:	F 364		3/10/10

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Based on observation, taste and temperature assessment, the facility failed to ensure that for one of two main dining observations, the food was not palatable or at the proper temperature.

Findings include:

Two main dining lunch observations were performed on 1/25/10 and 1/26/10. It was observed on 1/26/10, that the steam table used to keep hot foods hot had four separately controlled compartments. At 12:15 PM on 1/26/10, three of the four compartments were on, with the water in each compartment between 120-130 degrees Fahrenheit (F). The fourth compartment's water temperature was 100 degrees F.

At 12:30 PM on 1/26/10, the kitchen staff brought the lunch meal out on a multi-shelf wheeled cart. The kitchen staff placed the main lunch menu hot foods that were in metal containers into the three compartments that were 120-130 degrees, but did not check the water before they did this. The alternate meal choices (honey glazed chicken, cauliflower and steamed rice) were left on the cart used to bring the food into the main dining area. These metal containers were covered with tin foil.

During the dining observation, if a resident chose the alternate, the foil would be pulled back and the food removed from the metal container, and the foil would be replaced. It was observed after the first time, the foil was not secured but just laying on top of the metal container. At approximately 12:55 PM, the kitchen staff announced that all the meal tickets had been completed, but wanted to make sure if any resident wanted or needed any food.

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F 364	Continued From page 29 At this time, the kitchen staff was asked to make a meal of the alternate choices. The temperature of these foods were taken. The temperature of the chicken was 102 degrees F, the cauliflower was 108 degrees F and the rice was 140 degrees F. The cauliflower was also determined to be overcooked, as it could be mashed with a fork. An interview with the Dietary Manager (Employee #11) on 1/27/10, revealed he was not aware that the kitchen staff were not using all four compartments of the steam table or why the alternate menu choices were left on the cart used for transport. He also confirmed it was hard to keep cooked cauliflower palatable because it kept cooking even off the heat, resulting in overcooking.	F 364		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure food was prepared under sanitary conditions. Findings include:	F 371		3/10/10

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On a tour of the facility's kitchen at the Denton building on 1/25/10 at 8:30 AM, the following was observed: 1) there was an inadequate amount of sanitizer in the wiping cloth bucket; 2) there was wet-stacking of clean cups; and 3) the plastic covers of the flour and sugar storage bins were cracked, and scoops were being stored on the bin covers.

On 1/27/10 at 2:00 PM, a plate of Hungarian goulash with no cover was observed on the steam table in the Denton kitchen. The temperature of the goulash was 106.9 degrees Fahrenheit (F). A dietary aide communicated that the plate was being held for any resident who had missed lunch. The aide further explained that lunch plates kept for resident were normally covered and discarded by 12:45 PM. The Dietary Manager agreed that meals being held in the kitchen for residents should be held at 140 degrees F and discarded in a timely manner.
An initial tour of the kitchen in the main building was conducted at 8:20 AM on 1/25/10. This was after breakfast had been served and before the lunch meal was being prepped. During the tour, it was revealed that the freezer door appeared closed, but the temperature dial was reading 20 degrees Fahrenheit. An attempt to close the door securely was unsuccessful because of ice buildup on the door.

An observation of the steam table used for meal service in the main dining room before the noon meal, at 11:40 AM on 1/26/10, revealed the water reservoirs were filled with water that contained food particles which appeared to be beans, rice and unidentified food particles. An interview with the Dietary Manager on 1/26/10, at approximately 11:45 AM, revealed the night shift was

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F 371	Continued From page 31 responsible to clean the steam table and remove the water nightly. It was the responsibility of the day shift to replace the steam table with clean water in the reservoirs.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		3/10/10

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F 441	Continued From page 32 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interviews, the facility failed to ensure the following: 1) a safe and sanitary environment to prevent disease and/or infection transmission during meal service; 2) proper infection control practices by staff regarding wound care and body/biohazard specimen collection; and 3) proper storage and service of food/water. Findings include: During the noon meal observations in the main dining room on 1/25/10 and 1/26/10, it was observed that facility staff served residents their beverages and meals. Waterless hand cleanser was available at the two entrances to the main dining room. On 1/25/10, it was observed that facility staff members were serving beverages, pouring coffee, tea, juices, water and offering hot chocolate that was in packages. Staff was observed holding the individual glasses and cups while they poured the beverages. A resident in a wheelchair required repositioning to be placed correctly at the table. One employee pouring the beverages assisted this resident by pushing this resident's wheelchair into position. The employee then proceeded to return to pouring beverages without accessing the waterless hand cleanser (or hand sink) after the resident contact.	F 441		

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It was observed during both dining observations that staff would leave the dining room and then return to assist the residents. It was observed that staff did not always use the waterless hand cleanser (or hand sink) after their return to the dining room.

An interview with the infection control nurse (Employee #21) confirmed that staff should always use good handwashing techniques between food service and resident contact (such as moving a wheelchair), or returning to the dining room to assist with food service.

A random observation at 8:00 AM on 1/28/10, revealed a licensed practical nurse (LPN), Employee #22, at the 200 Hall nurses station placing filled Vacutainers into plastic bags. The Vacutainers had been placed directly on the counter of the desk at the nurses station. It was also observed that the infection control nurse was sitting at the nursing station.

An interview with Employee #22 at 8:30 AM on 1/28/10 confirmed these vacutainers contained blood specimens collected this morning. He acknowledged that they had been placed on the counter of the nurses station, to be placed in biohazard bags with the paperwork for the lab tests. Employee #22 indicated he would wipe off the counter after the Vacutainers were placed in biohazard bags with their paperwork, but also acknowledged he had not done this yet, after 30 minutes.

An interview with the infection control nurse (Employee #21) and the resident care manager (Employee #3) at 8:35 AM on 1/28/10, acknowledged these vacutainers should have

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been placed in the plastic "biohazard" bags immediately after collection and before leaving the individual resident's room. They also confirmed biohazard items should not be left to expose other surfaces.

Interviews with the infection control nurse during the survey revealed the facility had specific policies which described residents who shared the same infection could share rooms, known as cohorting; under specific conditions. These policies were for Clostridium Difficile (C diff), Methicillin resistant staphylococcus aureus (MRSA), and Vancomycin resistant enterococcus (VRE). The infection control nurse did confirm two residents were currently sharing a room, but one resident had shingles, the other didn't. The facility did not provide a specific policy for residents with shingles cohorting. The facility was not able to provide a general guideline or policy for cohorting that enabled staff to determine the appropriateness of this practice.

Review of the infection control manual revealed a section for a list of reportable diseases, but this list was not present in the manual. The infection control nurse was able to provide a list of reportable diseases, dated 12/5/07. This list did not identify any time frame to report these diseases.

An interview with the infection control nurse on 1/28/10, revealed all reportable diseases were treated the same as to reportability, but she did not know who was responsible to report. The facility could not provide a policy as to who was accountable to report these diseases.

Review of the reportable diseases for the local

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county jurisdiction revealed that the county identified specific diseases that were required to be reported immediately, and those that were to be reported within one working day.

Comparing the facility's list revealed the facility's list was incomplete with the local county's current requirements for reportable diseases and lacked five reportable diseases (animal bites/rabies suspected, CD4 lymphocyte counts less than 500/ul, hemolytic uremic syndrome, tuberculosis, and West Nile virus infection).

Resident #14

Resident #14 had resided at the facility since 10/10/07. Her current diagnoses included a stage three coccyx pressure sore requiring wound care.

Wound care was observed on 1/25/10, performed by the infection care nurse, Employee #21. Employee #21 prepared supplies, carrying the supplies into the room using a disposable plate and placed it at the head of the bed. It was observed the spray bottle of wound cleanser was placed directly on the bed. A plastic bag was placed at the foot of the bed for waste. Employee #21 washed her hands and then applied three layers (pairs) of disposable gloves.

Employee #21 removed the soiled dressing, discarding the dressing into the plastic bag for waste. She then removed one pair of gloves. Employee #21 sprayed the wound with the wound cleanser and then placed the wound cleanser at the foot of the bed, where it almost fell into the soiled waste bag, before Employee #21 caught it.

Employee #21 removed the second pair of gloves

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and then prepared to apply the clean dressing. Employee #21 acknowledged she did not have all her supplies, removed the third layer of gloves discarding them into the waste bag and left the room to obtain what was needed. Upon her return, she washed her hands and then applied a pair of gloves. Completing the procedure, Employee #21 removed the gloves, discarding them into the waste bag, tied the bag, gathered her items and went to the treatment cart outside the room, where she wiped the wound cleanser bottle with three alcohol swabs before putting it back into the cart.

Employee #21 indicated she used the multi-glove technique because it was hard on residents for staff to wash their hands every time they removed gloves. Employee #21 acknowledges she had no research to confirm that this practice was effective for not cross contaminating supplies. Employee #21 did confirm that when she removed soiled or contaminated gloves, she was required to remove a contaminated glove with the clean glove she just uncovered.

A review of the facility's policy for Using Gloves, revised 5/21/04, indicated "gloves do not replace hand hygiene measures.

A review of the facility's policy for Wound Care of Major Wounds, revised 5/21/04, indicated hands were to be washed between the "dirty" and "clean" portions of the wound care. This policy also indicated all supplies brought into a resident's room were to be placed on a clean impervious barrier.

An observation was made on 1/26/10, at approximately 11:30 AM, of fingersticks being

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completed on three residents. The observation took place on the 100 Hall. Employee #13 performed the fingersticks on each resident without any cleansing of the glucometer until after the third resident.

The Clinical Practices guideline entitled, "Clinical Services Policy and Procedure, Nursing Volume I, Laboratory/Diagnostic, Chapter 18," was presented when the facility was asked if there was a policy on the cleansing of the glucometer. The practice guideline stated that, "...after each use, wipe all surfaces of the glucometer with a Sani-Cloth to disinfect it. Disinfecting should be done in the resident's room with gloves."

On 1/29/10 at approximately 9:08 AM, staff were observed changing resident water pitchers on the 200 Hall. The Certified Nursing Assistant (CNA) was observed bringing water pitches out of the residents' rooms. The CNA placed the water pitchers taken from a resident's room into a clear trash bag attached to a distribution cart, the CNA then took clean water pitches off a shelf on the distribution cart and returned the clean pitches to the residents' bedside tables. The CNA did not wash their hands in-between handling the pitches being removed from the residents' rooms and the clean water pitches being distributed.

Immediately following the observation, the CNA, Employee #10, was interviewed. The CNA described the process of replacing the pitches, which occurred twice a day. The CNA indicated the pitches at the residents' bedsides were collected and emptied in the residents' sink, removed from the room and replaced as observed. The CNA confirmed they had not washed their hands in-between handling

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residents' used water pitchers and the clean ones being replaced. The observations were also reviewed with the Resident Care Manager, Employee #3, who was present at the time.

On 1/25/10 at 8:45 AM, an opened container of a high-calorie/high-protein supplement used at medication pass was observed to be placed on a bag of melted ice on a med cart at the 400 Hall of the Denton building. The temperature of the supplement was 68.1 degrees Fahrenheit (F). The instructions on the supplement container read, "Refrigerate prior to serving and refrigerate unused portion." The med pass nurse, Employee #17, communicated that he had opened the container 15 minutes earlier, and that the supplement was usually stored in the refrigerator.

On 1/26/10 at 7:40 AM, a dietary aide was observed to scoop out ice from the ice machine in the main kitchen, and then hold the tip of the scoop with her bare hands to keep the ice from falling out while transferring the ice to an ice chest.